DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 4 — 0 4

2. STATE: Vermont

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 5/1/04

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 V.S.C. §1396a(a)(13)(A)

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $ 33,333
b. FFY 2005 $ 00,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 4.19D pg 1 (title page) (04-04)
Att. 4.19D addendum A (04-04)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Att. 4/19D Pg 1 (Title Page) (02-22)
Att. 4.19D addendum A (02-22)

10. SUBJECT OF AMENDMENT:
Methods, Standards, and Principles for Establishing Medicaid Payment Rates for Long-Term Care Facilities

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Allen P. Gilbert, Deputy Sec., for

13. TYPED NAME:
Charles P. Smith

14. TITLE:
Secretary, Agency of Human Services

15. DATE SUBMITTED:
6/25/04

16. RETURN TO:
Roxanne Doty
Dept. of PATH
103 South Main Street
Waterbury VT 05671-1201

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JUL - 1 2004

18. DATE APPROVED: SEP 14 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: MAY - 1 2004

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Carmen Keller

22. TITLE: DD Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

STATE OF VERMONT

AGENCY OF HUMAN SERVICES

DIVISION OF RATE SETTING

METHODS, STANDARDS AND PRINCIPLES FOR ESTABLISHING MEDICAID PAYMENT RATES FOR LONG-TERM CARE FACILITIES

May 1, 2004

STATE OF VERMONT
AGENCY OF HUMAN SERVICES
DIVISION OF RATE SETTING

METHODS, STANDARDS AND PRINCIPLES FOR ESTABLISHING MEDICAID PAYMENT RATES FOR LONG-TERM CARE FACILITIES

MAY 2004

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Cite as Vermont Division of Rate Setting Rules (V.D.R.S.R.)

1 GENERAL PROVISIONS

1.1 Purpose

The purpose of these rules is to implement state and federal reimbursement policy with respect to nursing facilities providing services to Medicaid eligible persons. The methods, standards, and principles of rate setting established herein reflect the objectives set out in 33 V.S.A. §901 and balance the competing policy objectives of access, quality, cost containment and administrative feasibility. Rates set under this payment system are consistent with the efficiency, economy, and quality of care necessary to provide services in conformity with state and federal laws, regulations, quality and safety standards, and meet the requirements of 42 U.S.C. §1396a(a)(13)(A).

1.2 Scope

These rules apply to all privately owned nursing facilities and state nursing facilities providing services to Medicaid residents. Long-term care services in swing-bed hospitals, and Intermediate Care Facilities for the Mentally Retarded are reimbursed under different methods and standards. Swing-bed hospitals are reimbursed pursuant to 42 U.S.C. §1396l(b)(1). Intermediate Care Facilities for the Mentally Retarded are reimbursed pursuant to the *Regulations Governing the Operation of Intermediate Care Facilities for the Mentally Retarded* adopted by the Agency for the Department of Developmental and Mental Health Services and are subject to the Division's Accounting Requirements (Section 2) and Financial Reporting (Section 3).

1.3 Authority

These rules are promulgated pursuant to 33 V.S.A. §§904(a) and 908(c) to meet the requirements of 33 V.S.A. Chapter 9, 42 U.S.C. §§1396a(a)(13)(A) and §1396a(a)(30).

1.4 General Description of the Rate Setting System

A prospective case-mix payment system for nursing facilities is established by these rules in which the payment rate for services is set in advance of the actual provision of those services. A per diem rate is set for each facility based on the historic allowable costs of that facility. The costs are divided into certain designated cost categories, some of which are subject to limits. The basis for reimbursement within the Nursing Care cost category is a resident classification system that groups residents into classes according to their assessed conditions and the resources required to care for them. The costs in some categories are adjusted to reflect economic trends and conditions, and the payment rate for each facility is based on the per diem costs for each category.

1.5 Requirements for Participation in Medicaid Program

(a) Nursing facilities must satisfy all of the following prerequisites in order to participate in the Medicaid program:

(1) be licensed by the Agency, pursuant to 33 V.S.A. §7103(b),

(2) be certified by the Secretary of Health and Human Services pursuant to 42 C.F.R. Part 442, Subpart C, and

(3) have executed a Provider Agreement with the Agency, as required by 42 C.F.R. Part 442, Subpart B.

(b) To the extent economically and operationally feasible, providers are encouraged, but not required, to be certified for participation in the Medicare program, pursuant to 42 C.F.R. §488.3.

(c) Medicaid payments shall not be made to any facility that fails to meet all the requirements of Subsection 1.5(a).

1.6 Responsibilities of Owners

The owner of a nursing facility shall prudently manage and operate a residential health care program of adequate quality to meet its residents' needs. Neither the issuance of a per diem rate, nor final orders made by the Director or a duly authorized representative shall in any way relieve the owner of a nursing facility from full responsibility for compliance with the requirements and standards of the Agency of Human Services.

1.7 **Duties of the Owner**

The owner of a nursing facility, or a duly authorized representative shall:

(a) Comply with the provisions of Subsections 1.5 and 1.6 setting forth the requirements for participation in the Medicaid Program.

(b) Submit cost reports in accordance with the provisions of subsections 3.2 and 3.3 of these rules.

(c) Maintain adequate financial and statistical records and make them available at reasonable times for inspection by an authorized representative of the Division, the state, or the federal government.

(d) Assure that an annual audit is performed in conformance with Generally Accepted Auditing Standards (GAAS).

(e) Assure that the construction of buildings and the maintenance and operation of premises and programs comply with all applicable health and safety standards.

(f) Notwithstanding any other provision of these rules, any provider that fails to make a complete cost report filing within the time prescribed in subsection 3.3(a) or fails to file any other materials requested by the Division within the time prescribed shall receive no increase to its Medicaid rate until the first day of the calendar quarter after a complete cost report or the requested materials are filed, unless within an extension of time previously approved by the Division.

1.8 **Powers and Duties of the Division and the Director**

(a) The Division shall establish and certify to the Department of Prevention, Assistance, Transition and Health Access per diem rates for payment to providers of nursing facility services on behalf of residents eligible for assistance under Title XIX of the Social Security Act.

(b) The Division may request any nursing facility or related party or organization to file such relevant and appropriate data, statistics, schedules or information as the Division finds necessary to enable it to carry out its function.

(c) The Division may examine books and accounts of any nursing facility and related parties or organizations, subpoena witnesses and documents, administer oaths to witnesses and examine them on all matters over which the Division has jurisdiction.

(d) From time to time, the Director may issue notices of practices and procedures employed by the Division in carrying out its functions under these rules.

(e) The Director shall prescribe the forms required by these rules and instructions for their completion.

(f) Copies of each notice of practice and procedure, form, or set of instructions shall be sent to each nursing facility participating in the Medicaid program at the time it is issued. A compilation of all such documents currently in force shall be maintained at the Division, pursuant to 3 V.S.A. §835, and shall be available to the public.

(g) Neither the issuance of final per diem rates nor Final Orders of the Division which fail, in any one or more instances, to enforce the performance of any of the terms or conditions of these rules shall be construed as a waiver of the Division's future performance of the right. The obligations of the provider with respect to performance shall continue, and the Division shall not be estopped from requiring such future performance.

1.9 **Powers and Duties of the Department of Aging and Disabilities' Division of Licensing and Protection as Regards Reimbursement**

(a) The Division of Licensing and Protection of the Department of Aging and Disabilities shall receive from providers resident assessments on forms it specifies. The Department of Aging and Disabilities shall process this information and shall periodically, but no less frequently than quarterly, provide the Division of Rate Setting with the average case-mix scores of each facility based upon the Vermont version of 1992 RUGS-III (44 group version). This score will be used in the quarterly deter-

mination of the Nursing Care portion of the rate.

(b) The management of the resident assessment process used in the determination of case-mix scores shall be the duty of the Division of Licensing and Protection of the Department of Aging and Disabilities. Any disagreements between the facility's assessment of a resident and the assessment of that same resident by the audit staff of Licensing and Protection shall be resolved with the Division of Licensing and Protection and shall not involve the Division of Rate Setting. As the final rates are prospective and adjusted on a quarterly basis to reflect the most current data, the Division of Rate Setting will not make retroactive rate adjustments as a result of audits or successfully appealed individual case-mix scores.

1.10 **Computation of and Enlargement of Time; Filing and Service of Documents**

(a) In computing any period of time prescribed or allowed by these rules, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday a Sunday, or a state or federal legal holiday, in which event the period runs until the end of the next day which is not a Saturday, a Sunday, or a state or federal legal holiday.

(b) For the purposes of any provision of these rules in which time is computed from the receipt of a notice or other document issued by the Division or other relevant administrative officer, the addressee of the notice shall be rebuttably presumed to have received the notice or other document three days after the date on the document.

(c) When by these rules or by a notice given thereunder, an act is required or allowed to be done at or within a specified time, the relevant administrative officer, for just cause shown, may at any time in her or his discretion, with or without motion or notice, order the period enlarged. This subsection shall not apply to the time limits for appeals to the Vermont Supreme Court or Superior Court from Final Orders of the Division or Final Determinations of the Secretary, which are governed by the Vermont Rules of Appellate Procedure and the Vermont Rules of Civil Procedure respectively.

(d) Filing shall be deemed to have occurred when a document is received and date-stamped as received at the office of the Division or in the case of a document directed to be filed under this rule other than at the office of the Division, when it is received and stamped as received at the appropriate office. Filings with the Division may be made by telefacsimile (FAX), but the sender bears the risk of a communications failure from any cause. Filings shall be made by electronic data transfer at such time as appropriate software and filing procedures are prescribed by the Division pursuant to subsection 1.8(d).

(e) Service of any document required to be served by this rule shall be made by delivering a copy of the document to the person or entity required to be served or to his or her representative or by sending a copy by prepaid first class mail to the official service address. Service by mail is complete upon mailing.

1.11 **Representation in All Matters before the Division**

(a) A facility may be represented in any matter under this rule by the owner (in the case of a corporation, partnership, trust, or other entity created by law, through a duly authorized agent), the nursing facility administrator, or by a licensed attorney or an independent public accountant.

(b) The provider shall file written notification of the name and address of its representative for each matter before the Division. Thereafter, on that matter, all correspondence from the Division will be addressed to that representative. The representative of a provider failing to so file shall not be entitled to notice or service of any document in connection with such matter, whether required to be made by the Division or any other person, but instead service shall be made directly on the provider.

1.12 **Severability**

If any part of these rules or their application is held invalid, the invalidity does not affect other provisions or applications which can be

given effect without the invalid provision or application, and to this end the provisions of these rules are severable.

1.13 **Effective Date**

(a) These rules are effective from January 29, 1992, (as amended June 18, 1993, July 1, 1994, January 4, 1995, January 1, 1996, January 1, 1997, July 1, 1998, May 1, 1999, July 1, 1999, August 1, 1999, July 1, 2001, November 1, 2002, and May 1, 2004).

(b) Application of Rule: Amended provisions of this rule shall apply to:

(1) all cost reports draft findings issued after the effective date of the most recent amendment for cost reporting periods after facilities' fiscal years 2001, and

(2) all rates set after the effective date of the most recent amendment.

(c) With respect to any administrative proceeding pending on the effective date of the most recent amendment the Director or the Secretary may apply any provision of such prior rules where the failure to do so would work an injustice or substantial inconvenience.

2 ACCOUNTING REQUIREMENTS

2.1 **Accounting Principles**

(a) All financial and statistical reports shall be prepared in accordance with Generally Accepted Accounting Principles (GAAP), consistently applied, unless these rules authorize specific variations in such principles.

(b) The provider shall establish and maintain a financial management system which provides for adequate internal control assuring the accuracy of financial data, safeguarding of assets and operational efficiency.

(c) The provider shall report on an accrual basis. The provider whose records are not maintained on an accrual basis shall develop accrual data for reports on the basis of an analysis of the available documentation. In such a case, the provider's accounting process shall provide sufficient information to compile data to satisfy the accrued expenditure reporting requirements and to demonstrate the link between the accrual data reports and the non-accrual fiscal accounts. The provider shall retain all such documentation for audit purposes.

2.2 **Procurement Standards**

(a) Providers shall establish and maintain a code of standards to govern the performance of its employees engaged in purchasing goods and services. Such standards shall provide, to the maximum extent practical, open and free competition among vendors. Providers should participate in group purchasing plans when feasible.

(b) If a provider pays more than a competitive bid for a good or service, any amount over the lower bid which cannot be demonstrated to be a reasonable and necessary expenditure that satisfies the prudent buyer principle is a non-allowable cost.

2.3 **Cost Allocation Plans and Changes in Accounting Principles**

With respect to the allocation of costs to the nursing facility and within the nursing facility, the following rules shall apply:

(a) [Repealed]

(b) Providers that have costs allocated from related entities included in their cost reports shall include, as a part of their cost report submission, a summary of the allocated costs, including a reconciliation of the allocated costs to the entity's financial statements, which must also be submitted with the Medicaid cost report. In the case of a home office or related management company, this would include a completed Home Office Cost Statement. The provider shall submit this reconciliation with the Medicaid cost report.

(c) No change in accounting principles or methods or basis of cost allocation may be made without prior written approval of the Division.

(d) Any application for a change in accounting principle or a change in the method or basis of cost allocation, which has an effect on the